



# Cultural and Linguistic Services in the Healthy Families Program 2007-08



California Managed Risk Medical Insurance Board

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# Cultural Competency

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Definition: "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."

Office of Minority Health  
1999 (as adapted from Cross, 1989)

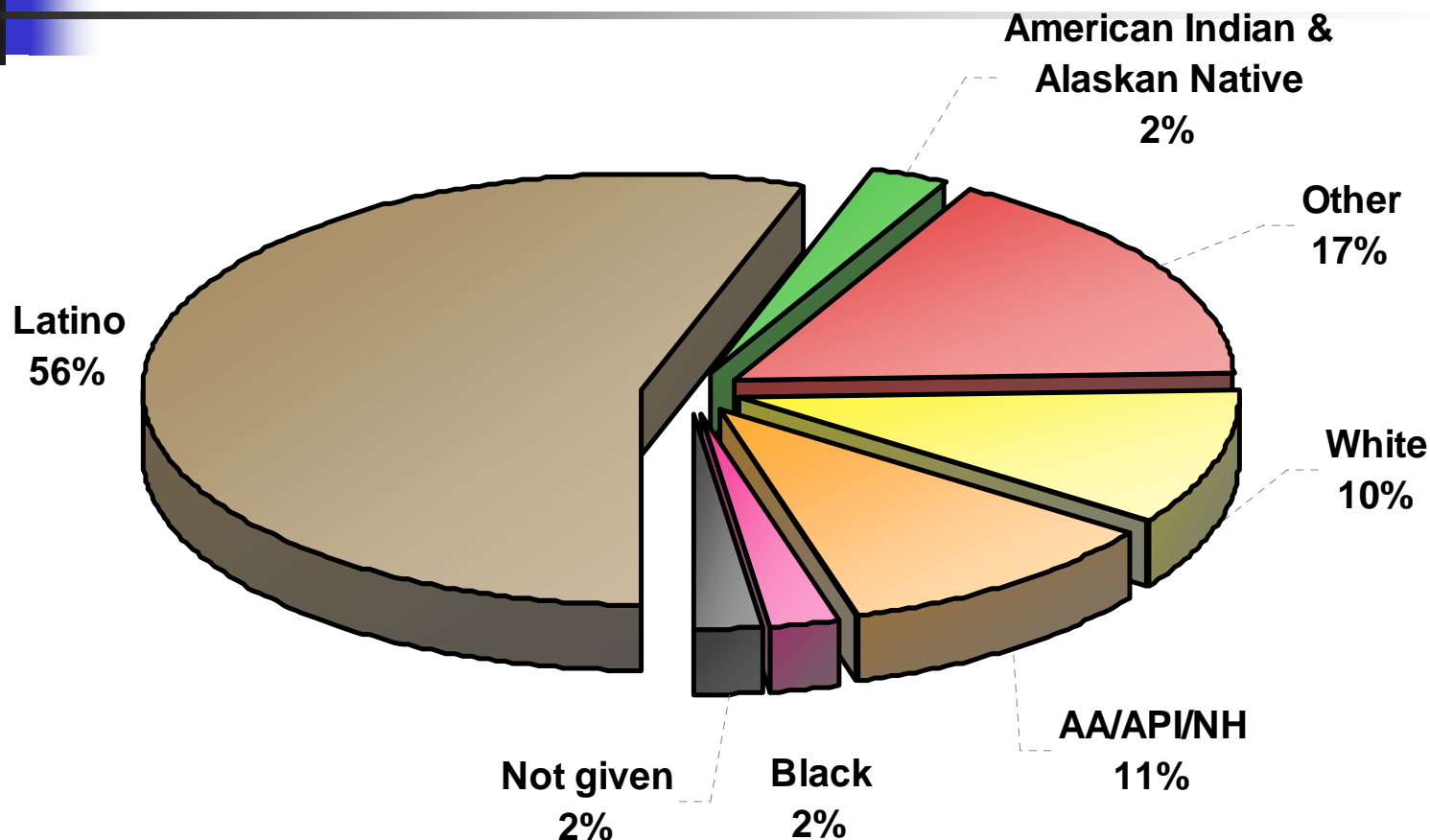
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# Cultural Competency Helps Ensure Quality of Care

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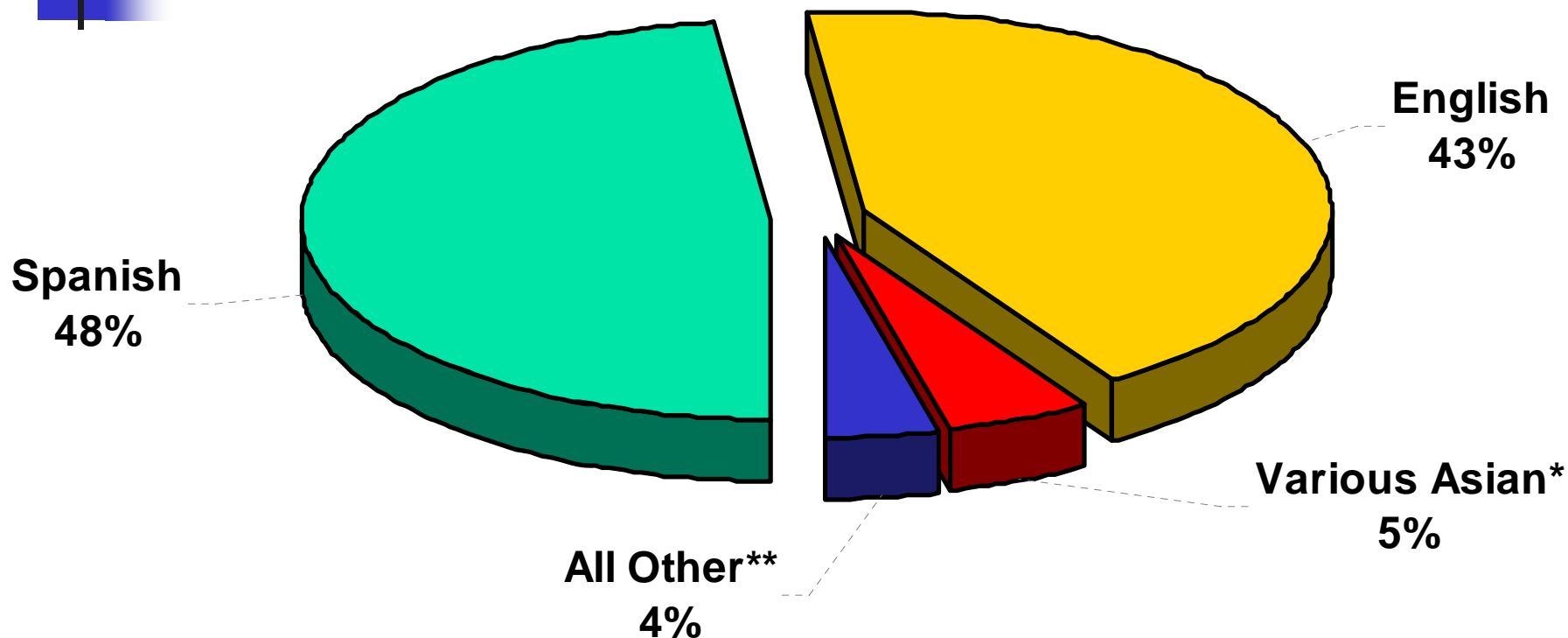
- Misunderstandings in language and culture can affect:
  - Access to health care services
  - Greater emergency room use
  - Comprehension of diagnoses
  - Ability to follow treatment plans
  - Informed decision-making

# Ethnicity of HFP Subscribers



Enrollment data from MAXIMUS, Dec 31, 2007

# Preferred languages spoken by HFP families



Enrollment data from MAXIMUS, Dec 31, 2007

\*Chinese, Vietnamese, Korean

\*\* E.g. Russian, Armenian, Farsi, Italian

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# HFP Contract Requirements

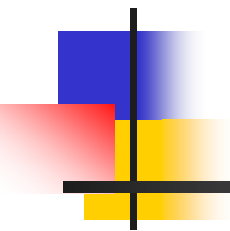
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- Assess C&L needs (once every 4 years through the Group Needs Assessment)
- Annually report on C&L services provided
- Inform members of available language assistance services
- Inform providers of members' language preferences
- Provide 24-hour access to interpreters

# HFP Contract Requirements (cont'd)

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- Ensure minors are not used as interpreters, except in extraordinary circumstances, like emergency care
- Ensure bilingual proficiency at medical and non-medical points of contact
- Translate written materials
- Develop internal systems to meet the C&L needs of members

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# Healthy Families Program Cultural and Linguistic Services Survey 2007-08

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Reviewed by  
Monica Hau Le, MD

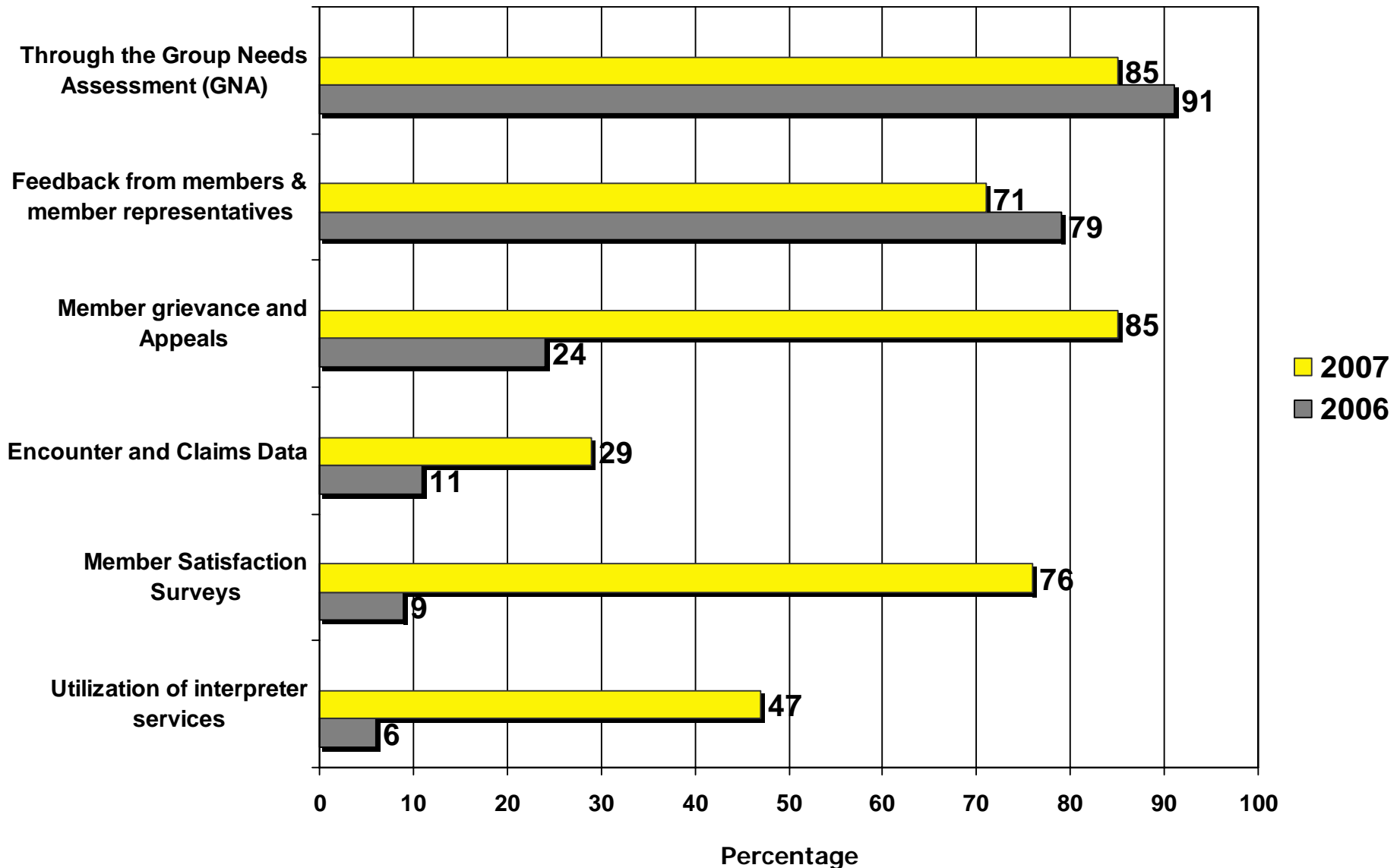


# HFP Cultural and Linguistic (C&L) Services Survey

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- First plan survey conducted in 2002
- Survey revisions
  - 2005 to reflect contract requirements
  - 2006 address patient advocacy concerns
- Report to Board October 2007
  - Available at [www.mrmib.ca.gov](http://www.mrmib.ca.gov)

# Methods plans use to assess C&L needs



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# Informing Members of Language Assistance Services

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- All plans report giving at least 5 different pieces of information to patients regarding language access services, including:
  - Availability of interpreters at no cost
  - Patient's right to:
    - Request an interpreter
    - NOT use a family member
    - Receive subscriber material in threshold languages
    - File a grievance if linguistic needs not met

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# Making Providers Aware of Language Preferences

- All health plans report making providers aware of language preferences
- Two of 5 dental plans do not make this information readily available to providers
- Two of 3 vision plans make this information readily available to providers

# How do plans provide 24-hour C&L services?

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- Telephone language line (97%)
- Face-to-face interpreters (74%)
  - Advanced notice 24-72 hours
- Community-based organizations (38%)
- No independent medical interpretation certification system exists

# Are minors used as interpreters?

- Plans report that they are not aware of any “extraordinary circumstances” when minors were used as interpreters.
- A few plans responded that their policies explicitly discourage the use of minors as interpreters
- MRMIB has received no complaints of minors being used as interpreters

# Verification of Providers' Bilingual Proficiency

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- This is a contract requirement very few plans are meeting
- All 34 plans rely largely on self-report
- 4 plans add a self-evaluation assessment
- Only 2 plans have a verbal verification system in place, with another in development

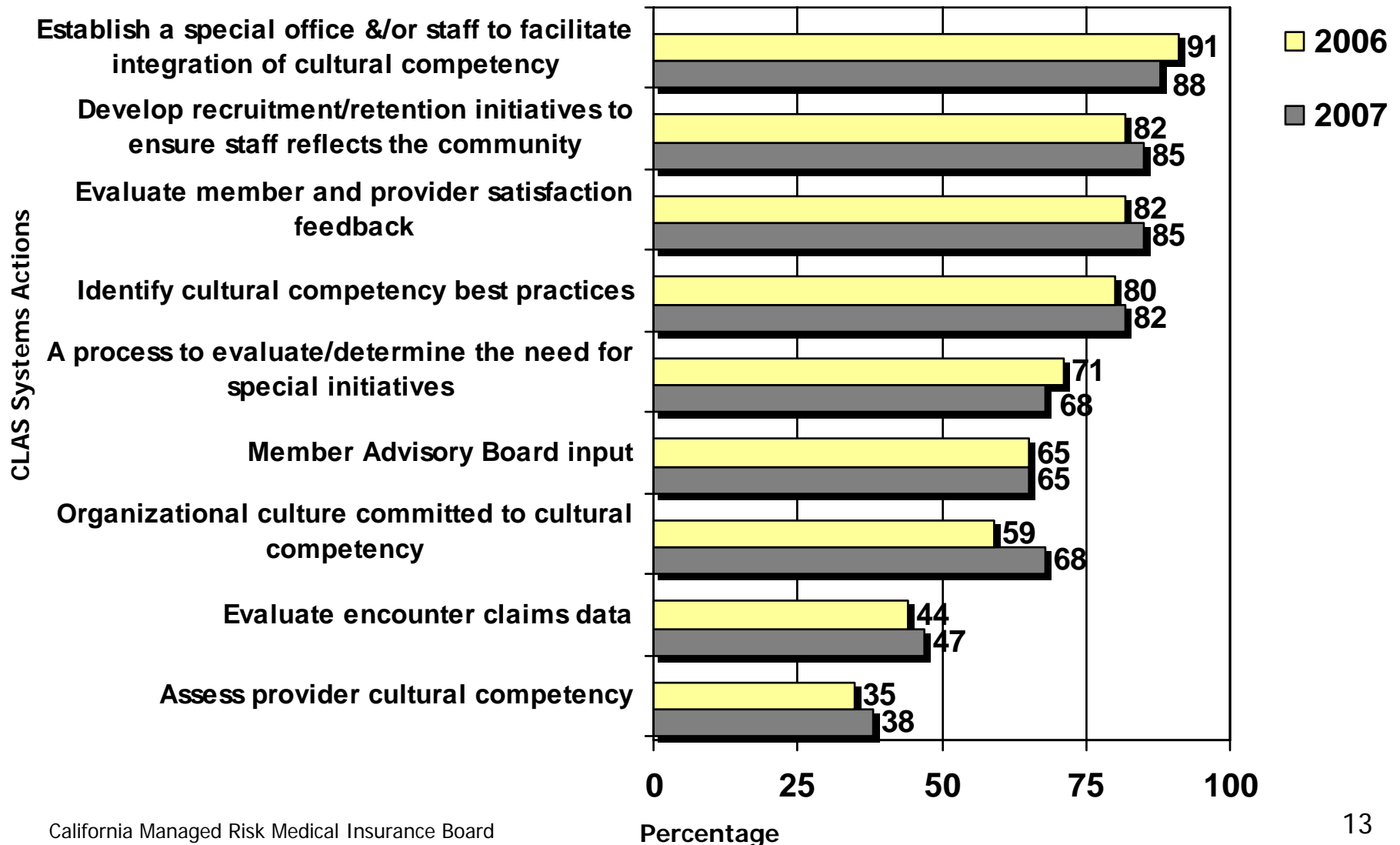
# Translation of Written Materials

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- Almost all (33 out of 34) plans use translation companies
- 71% use a qualified translator to proofread and edit documents
- Less than half (44%) use an internal committee to review materials for cultural appropriateness
- Only 38% (12 plans) do “back translations”
- 21 plans make materials available in alternate formats



# Development of Internal C&L Systems



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# How Plans Monitor and Evaluate Language Services

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- 97% Grievance and Appeals Process
- 74% Subscriber Feedback
- 68% Subscriber Plan Meetings
- 62% Review Requests for Interpreter Services
- 15% Encounter Claims Data Review

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# DMHC Language Assistance Program

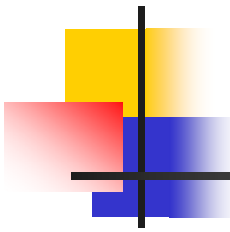
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# SB 853

## (Chapter 713, Statutes of 2003)

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- Requires all California health plans to provide language access services
  - DMHC regulations became effective February 23, 2007
  - Plans must file Language Assistance Program (LAP) policies and procedures with DMHC by July 1, 2008
  - Plans implement LAP on January 1, 2009

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# DMHC Language Assistance Program (LAP) Requirements

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- Enrollee Assessment
- Provide Language Assistance Services
- Staff Training
- Compliance Monitoring

# DMHC Requirements for Language Assistance Programs

- Plans must provide interpreter services at:
  - All points of contact (medical and non-medical)
  - No cost to enrollees
- Plans must make providers aware of the plan's processes for making interpretation available to enrollees at no cost
- Plans must inform enrollees of their right to file a grievance, seek IMR

# DMHC Requirements for LAP (cont'd)

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- Plans must translate written materials (vital documents)
- Plans must ensure language proficiency of individuals providing interpretation services
  - Regulations are silent about ensuring language proficiency of providers who speak languages other than English

# DMHC Language Proficiency Standards

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- Plans must ensure proficiency of individuals providing translation and interpretation services
  - Documented and demonstrated proficiency in both English and the other language
  - Knowledge of health care terminology and concepts relevant to health care delivery systems in both languages
  - Education and training in interpreting ethics, conduct and confidentiality



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# HFP C&L Survey Tool: Findings from Dr. Le

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# HFP C&L Survey Tool

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- What's Good: Electronic filing, response rate, tool reflects contract language, advocates' input
- Problems:
  - Unclear instructions (email addresses/forms)
  - Qualitative questions
  - Internal validity concerns
  - Directive questions (CBO, "I speak" cards)

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# Survey Tool *Solutions*

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- Revise survey questions
  - Shorten survey to 15 questions (from 36)
  - Limit word count for qualitative responses
- Revise survey collection method and frequency
  - Use automated tools to aggregate data for efficiency
  - Computerized submission will be time stamped
  - Evaluate appropriate time intervals
- Re-evaluate “best practice” approaches

# Plan Reporting of C&L Practices

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- What's Good: Easy to collect, limits staff resources needed
- Problems:
  - Self-report can be an unreliable
  - Cut and paste responses
  - No verification mechanism

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# Suggested Improvements for Monitoring C&L Practices

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- Obtain information from DMHC site audits
- Contract with DMHC to monitor HFP practices not included in DMHC regulations, such as:
  - Recording language needs in enrollee medical records
  - Ensuring minors are not used as interpreters
  - Ensuring compliance of subcontractors

# Suggested Improvements (cont'd)

- Have plans report data on utilization of interpreter services
  - 24-hr translation line or face-to-face interpreter requests
  - Number of requests filled, if not why not?
- Review plan resources (infrastructure) such as staff and budget dedicated to C&L services

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# Challenges Ahead

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- How to enforce HFP contractual obligations with limited staff, reduced plan rates
- Evaluate how C&L services should be considered along with other quality standards for decisions about contract renewal

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# Next Steps

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- Collaborate with DMHC on enforcement and monitoring efforts
  - Obtain cost estimate for using DMHC to monitor HFP C&L requirements
- Encourage plan motivation by recognizing/rewarding innovation



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## Next Steps (cont'd)

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- Continue to incorporate C&L standards in other quality and performance initiatives (e.g., mental health evaluation)
- Use Quality Advisory Committee to evaluate performance measures that address C&L competency

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# Questions?

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